Excelsior College Examination

Content Guide for

Differences in Nursing Care: Area B (Associate Level)

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Important information to help you prepare for this Excelsior College Examination

General Description of the Examination

The Excelsior College Examination in Differences in Nursing Care: Area B measures knowledge and understanding of the various health care needs and problems encountered by the associate degree nurse. Questions are based on the common and specific manifestations of these needs and problems and the nursing care actions properly associated with them. Questions pertain to patients of various age groups in the proportion that members of these groups use health care services. Questions concern both acute and long-term needs and problems of medical, surgical, psychiatric, and pediatric patients.

The examination requires you to possess the technical vocabulary and knowledge of anatomy and physiology, microbiology, and emotional and physical development generally expected of the associate degree nurse. The examination requires you to demonstrate knowledge of the theoretical framework for each content area as well as the ability to apply this knowledge to nursing practice using the nursing process.

■ Uses for the Examination

Excelsior College, the test developer, recommends granting five (5) semester hours of lower-level undergraduate credit to students who receive a letter grade of C or higher on this examination. This recommendation is endorsed by the American Council on Education. Other colleges and universities also recognize this exam as a basis for granting credit or advanced standing. Individual institutions set their own policies for the amount of credit awarded and the minimum acceptable score. Before taking the exam, you should check with the institution from which you wish to receive credit to determine whether credit will be granted and/or to find out the minimum grade required for credit.

■ Examination Length and Scoring

The examination consists of approximately 120 four-option multiple-choice questions, some of which are unscored, pretest questions. You will have three (3) hours to complete the examination. Since you will not be able to tell which questions are being pretested, you should do your best on all of them. Scores are based on ability level as defined in the item response theory (IRT) method of exam development, rather than simply on your total number of correct answers. Your score will be reported as a letter grade.

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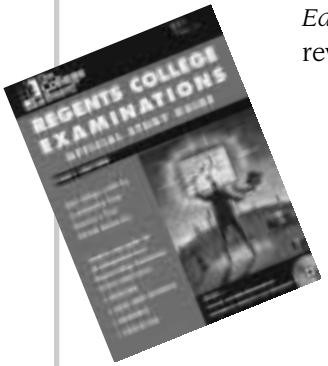

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Examination Objectives

You will be expected to demonstrate the ability to

1. identify the typical patterns of deviation from wellness associated with each content area;
2. identify the differences in nursing care that result from:
   a. manifestations of the specific health problems;
   b. the influence of culture on the patient's perception of illness and health care;
   c. the individualized response of the patient to illness;
3. apply knowledge of the theoretical framework for each content area when using the nursing process to provide direct care to patients.

Note Concerning Wording of Nursing Diagnoses

The North American Nursing Diagnosis Association (NANDA) continually revises and updates its listing of diagnostic categories, defining characteristics, and etiological factors. For example, between 1989 and 1991 the term "potential for" was revised to "high risk for." In 1994, the term was revised to "risk for." Questions on the examination that include nursing diagnoses are not intended to test your knowledge of current wording or phrasing. The questions are intended to test your ability to recognize nursing diagnoses that result from nursing assessments. For the purposes of the examination, all diagnoses should be considered correctly worded, even if a newer version of the diagnosis is being used by NANDA.

Content Outline

The major content areas on the examination and the percent of the examination devoted to each content area are listed below.

CONTENT AREA	PERCENT OF THE EXAMINATION
I. Behavioral Responses — Observable Responses of the Individual to Life Stressors	40%
II. Regulatory Mechanisms	25%
III. Metabolic Mechanisms	25%
IV. Congenital Anomalies, Genetic Disorders, and Developmental Problems	10%
Total	100%

I. Behavioral Responses — Observable Responses of the Individual to Life Stressors (40%)

A. Theoretical framework — basis for care

1. Types of behavioral responses
   a. Affective responses
      1) Persons who exhibit loss/grief responses, including denial, anger, and bargaining (for example: persons who have experienced sudden infant death syndrome [SIDS], a patient recently diagnosed with chronic renal failure)
      2) Persons who exhibit elated behavior, including psychomotor hyperactivity, euphoria, and flight of ideas
      3) Persons who exhibit depressed behavior, including psychomotor retardation, disruption in sleep and eating patterns, social isolation, and disturbance in self-esteem
      4) Persons who exhibit behaviors indicative of bipolar moods, including elation/depression

b. Anxiety responses

1) Persons who exhibit anxiety responses (for example: persons with generalized anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder, specific phobia, and social phobia)

2) Persons who express anxiety through dissociative disorders (for example: amnesia, fugue, dissociative identity disorder)

c. Somatoform psychophysiological responses (for example: ulcerative colitis, impotence, conversion disorder, hypochondriasis)

d. Withdrawal responses — psychogenic withdrawal from reality, including delusions, hallucinations, paranoid behavior, and autistic behavior (for example: schizophrenia and other psychotic disorders)

e. Aggressive responses

1) Persons who demonstrate self-destructive behavior, including suicide, substance abuse, and eating disorders

2) Persons who demonstrate antisocial behavior (for example: those who abuse or neglect adults and children, those with personality disorders)

f. Disruptive responses (for example: attention-deficit hyperactivity disorder, conduct disorder)

g. Dysfunctional coping behaviors in response to situational crises, including anger, withdrawal, denial, and dissociation (for example: as manifested by victims of rape, child abuse, spouse abuse, and elder abuse)

h. Alterations in behavior related to organic mental disorders, including delirium, memory impairment, loss of impulse control, and wandering (for example: dementia of the Alzheimer's type, vascular dementia, dementia due to HIV disease, Wernicke-Korsakoff syndrome, Huntington's chorea)

2. Factors influencing an individual's behavioral responses

a. Personality characteristics (for example: introverted, suspicious, rigid, passive, aggressive)

b. Developmental level (for example: trust vs. mistrust; oral stage)

c. Use of defense mechanisms (for example: denial, projection, regression)

d. Interpersonal experiences (for example: family roles and relationships, peer relationships)

e. Socioeconomic and cultural factors (for example: race, religion, nationality, lifestyle, environmental factors, occupation, education)

f. Precipitating event (for example: rape, divorce, illness, situational and maturational crises)

g. Genetic background (for example: bipolar disorders, alcoholism, Alzheimer's disease)

h. Substance abuse (for example: food, alcohol, chemical agents)

i. Nutritional status (for example: potassium imbalance)

3. Theoretical concepts that help explain variations in behavioral responses. (This area includes general concepts developed by the individuals listed, but not specific quotations from these individuals.)

a. Biological theories

1) Genes

2) Hormones

3) Neurotransmitters

b. Psychosocial theories

1) Intrapsychic theory (Sigmund Freud)

2) Developmental stages and tasks (Erik Erikson)

3) Hierarchy of needs (Abraham Maslow)

4) Social-interpersonal relationships (Harry Stack Sullivan)

5) Crisis theory (Gerald Caplan)

4. Therapeutic modalities
    a. Therapeutic nurse-patient relationship
    b. Therapeutic milieu
    c. Crisis intervention
    d. Community mental health programs (for example: Overeaters Anonymous, Alcoholics Anonymous)
    e. Behavior modification therapy
    f. Individual psychotherapy
    g. Group psychotherapy
    h. Family therapy
    i. Occupational/recreational therapy
    j. Reminiscing therapy
    k. Relaxation therapy
    l. Cognitive therapy
    m. Detoxification programs
    n. Somatic therapies
        1) Psychopharmacology
            (a) Antipsychotic drugs
            (b) Antianxiety/antihistamines
            (c) Antidepressant drugs
            (d) Antimanic drugs (lithium)
            (e) Antiparkinsonian drugs
            (f) Central nervous system stimulants
            (g) Anticonvulsant drugs
        2) Electroconvulsive therapy
        3) Phototherapy

B. Nursing care related to theoretical framework

1. ***Assessment*** — gather and synthesize data about the patient's health status in relation to the patient's functional health patterns
    a. Gather assessment data
        1) Obtain the patient's health history (for example: subjective symptoms, medications, diet, past illnesses, health habits, family history, usual coping mechanisms)
        2) Assess factors influencing the patient's behavioral responses (see IA2)
        3) Obtain objective data related to the patient's behavioral responses (for example: body language, affect, personal appearance, psychomotor activity, ritualistic behaviors, communication patterns, mental status)
        4) Review laboratory and other diagnostic data (for example: dexamethasone levels, lithium levels, electroencephalogram [EEG])
    b. Synthesize assessment data (see IB1a[1-4])

2. ***Analysis*** — identify the nursing diagnosis (patient problem) and determine the expected outcomes (goals) of patient care
    a. Identify actual or potential nursing diagnoses (for example: disturbance in self-concept related to biochemical imbalance; ineffective individual coping related to maturational crisis; altered thought processes related to delusion and/or hallucinations; risk for violence related to impaired ability to control aggression; altered nutrition: less than body requirements related to reluctance to eat)
    b. Set priorities (for example: based on Maslow's hierarchy of needs, based on the patient's developmental level)
    c. Establish expected outcomes (patient-centered goals) for care (for example: patient will verbalize perception of body image that is congruent with reality, patient will verbalize feelings of anger and loss, patient will seek assistance when delusions become threatening, patient will not harm self or others, patient will gain one pound in three days)

3. ***Planning*** — formulate specific strategies to achieve the expected outcomes
    a. Consider factors influencing the patient's behavioral responses in planning patient care (see IA2)

b. Plan nursing measures on the basis of established priorities to help the patient achieve the expected outcomes (for example: help the patient explore negative self-perceptions, provide a nonthreatening environment for the patient to practice risk-taking, do not reinforce the patient's delusions through discussion or validation, reduce environmental stimulation)

4. ***Implementation*** — carry out nursing plans designed to move the patient toward the expected outcomes
   a. Use nursing measures to provide for the patient's physiological needs (for example: monitor vital signs, provide dietary instruction for patients with stress-related gastrointestinal problems, monitor elimination patterns of the depressed patient)
   b. Use therapeutic communication skills (for example: to clarify the patient's thinking, to encourage a higher level of functioning)
   c. Use nursing measures to provide for patient safety (for example: provide a structured milieu, observe suicide precautions, apply restraints, decrease or increase environmental stimuli, provide for patient safety before and after electroconvulsive therapy [ECT], prevent destructive activity through use of de-escalation techniques)
   d. Use nursing measures to increase the patient's level of functioning (for example: encourage participation in patient government, encourage involvement in reality orientation groups, use music therapy, use group therapy, use reminiscing therapy, encourage activities of daily living [ADLs] for the patient with Alzheimer's disease)
   e. Use nursing measures to provide the patient with alternate methods of dealing with stressors (for example: encourage patient's interests in hobbies, encourage verbalization of thoughts and feelings, encourage the patient with depression to externalize anger, assist the patient to develop or strengthen support systems, provide age-appropriate diversionary activities)
   f. Use nursing measures to assist the patient to maintain optimal function (for example: refer patient to Alcoholics Anonymous, Overeaters Anonymous; encourage participation in supportive psychotherapy or family therapy)
   g. Use nursing measures specific to prescribed medications (for example: monitor compliance with monoamine oxidase [MAO] diet, monitor the intake and output of the patient receiving lithium, monitor for side effects of medications)
   h. Provide information and instruction (for example: instruct the patient regarding relaxation techniques, provide information about problem-solving techniques, provide instruction regarding the need for compliance with lithium therapy)

5. ***Evaluation*** — appraise the effectiveness of the nursing interventions relative to the nursing diagnosis and the expected outcomes
   a. Assess and report the patient's response to nursing actions (for example: verbalized freely, anxiety decreased from +3 to +1, gained weight, assumed responsibility for personal hygiene, increased acting out in group)
   b. Revise the patient's plan of care as necessary (for example: encourage the patient to take more responsibility in patient government as self-esteem increases, recommend an increase in the patient's privileges, introduce the patient to social interaction in groups, renegotiate no-suicide contract)

II. Regulatory Mechanisms (25%)

This area includes the adrenal gland, thyroid gland, pituitary gland, parathyroid gland, and kidney. This area focuses on the nursing care of patients with health problems such as myxedema, Graves' disease, Cushing's syndrome, Addison's disease, pheochromocytoma, diabetes insipidus, acromegaly, nephrotic syndrome, renal calculi, and renal failure.

A. Theoretical framework — basis for care

1. Types of regulatory disorders
   a. Disorders related to excess production of hormones (for example: pheochromocytoma, Graves' disease, Cushing's syndrome, acromegaly)
   b. Disorders related to deficient production of hormones (for example: myxedema, Addison's disease, diabetes insipidus, hypoparathyroidism)
   c. Disorders related to impaired renal function (for example: acute and chronic renal failure, renal calculi, glomerulonephritis, nephrosis, nephrotic syndrome)
2. Clinical manifestations of regulatory disorders
   a. Altered respiratory functioning (for example: dyspnea, crackles, wheezes, hypoventilation)
   b. Altered circulatory functioning (for example: tachycardia, hypertension, bradycardia, hypotension)
   c. Altered nutrition (for example: weight loss, weight gain)
   d. Altered elimination (for example: constipation, diarrhea, hematuria, oliguria, anuria, dysuria, polyuria)
   e. Altered activity (for example: hyperactivity, hypoactivity)
   f. Altered comfort (for example: fatigue, pain)
   g. Altered appearance (for example: buffalo hump, moon face, exophthalmos, goiter)
   h. Altered mental status (for example: mood swings, lethargy, coma)
   i. Altered integument (for example: dry skin, pruritus, edema, friability, changes in turgor, changes in color)
   j. Altered fluid and electrolyte balance (for example: hypernatremia, metabolic acidosis, hypercalcemia, hyper/hypokalemia, hyper/hypovolemia)
   k. Altered sensory perception (for example: auditory and visual changes)
3. Factors influencing the patient's response to regulatory disorders
   a. Age and physiological factors (for example: allergies, body surface area, immobility, age-related circulatory changes)
   b. Psychological factors (for example: stress, cognitive ability, body image, coping mechanisms)
   c. Nutritional status (for example: obesity, malnutrition)
   d. Presence of other illness (for example: infection, hypertension, diabetes mellitus, other chronic illnesses)
   e. Socioeconomic and cultural factors (for example: health practices, lifestyle, occupation, education, environmental factors)
   f. Availability of support systems (for example: family, friends, community resources)
4. Theoretical basis for interventions related to regulatory disorders
   a. Medications (for example: analgesics, hormones, electrolytes, antithyroid agents, immunosuppressive agents)
   b. Preoperative and postoperative care (for example: thyroidectomy, adrenalectomy, hypophysectomy, nephrectomy, renal transplant)
   c. Treatment modalities (for example: dietary modifications, hemodialysis, peritoneal dialysis, lithotripsy)
   d. Health instruction (for example: rationale for lifestyle changes, risk factors, preventive measures)

B. Nursing care related to theoretical framework

1. *Assessment* — gather and synthesize data about the patient's health status in relation to the patient's functional health patterns
   a. Gather assessment data
      1) Obtain the patient's health history (for example: subjective symptoms, diet, medications, past illnesses, family history, impact of illness on family/occupational roles and self-image)
      2) Assess factors influencing the patient's response to regulatory disorders (see IIA3)
      3) Obtain objective data related to the patient's regulatory disorder (for example: alterations in the vital signs, integument, sleep patterns, intake and output)
      4) Review laboratory and other diagnostic data (for example: urine tests, hormone levels, blood chemistry, scans, biopsies)
   b. Synthesize assessment data (see IIB1a[1-4])

2. *Analysis* — identify the nursing diagnosis (patient problem) and determine the expected outcomes (goals) of patient care
   a. Identify actual or potential nursing diagnoses (for example: disturbance in body image related to change in appearance, activity intolerance related to fatigue, ineffective individual coping related to inability to manage stressors, impaired gas exchange related to fluid overload)
   b. Set priorities (for example: based on Maslow's hierarchy of needs, based on the patient's developmental level)
   c. Establish expected outcomes (patient-centered goals) for patient care (for example: patient will participate in grooming, patient will increase participation in activities, patient will identify one significant stressor, patient's arterial blood gas values will be within normal limits)

3. *Planning* — formulate specific strategies to achieve the expected outcomes
   a. Consider factors influencing the patient's response to regulatory disorders (see IIA3)
   b. Plan nursing measures on the basis of established priorities to help the patient achieve the expected outcomes (for example: plan time for the patient to verbalize feelings about changed appearance, schedule rest periods, select relaxation techniques that are appropriate for the patient, plan a fluid restriction schedule)

4. *Implementation* — carry out nursing plans designed to move the patient toward the expected outcomes
   a. Use nursing measures to provide a safe environment (for example: provide suction apparatus for the patient following a thyroidectomy, regulate environmental temperature for the patient with myxedema, provide instruction about implications of corticosteroid regimen)
   b. Use nursing measures to promote comfort (for example: provide temperature control for a patient with Graves' disease, provide skin care for a patient with pruritus)
   c. Use nursing measures specific to prescribed medications (for example: monitor blood glucose in a patient who is receiving corticosteroid medications, monitor cardiac function in a patient who is receiving a thyroid medication, monitor calcium levels in a patient who is receiving parathyroid hormone)
   d. Use nursing measures to prevent/minimize complications due to regulatory disorders (for example: closely observe the patient following a thyroidectomy, monitor bowel elimination for the patient with myxedema)

e. Use nursing measures to enhance utilization of coping mechanisms and support systems (for example: encourage verbalization of feelings about changed body image; provide information about home health agencies, social services)

f. Provide information and instruction (for example: provide the patient's family with information regarding condition and treatment to enhance patient compliance, provide instruction about dietary management for the patient with impaired renal function)

5. *Evaluation* — appraise the effectiveness of the nursing interventions relative to the nursing diagnosis and the expected outcomes

a. Assess and report the patient's response to nursing actions relative to the expected outcomes (for example: increased activity levels in the patient with hypothyroidism, weight loss or gain for a child with nephrotic syndrome, decreased pain in the patient with renal calculi)

b. Revise the patient's plan of care as necessary (for example: increase observation of the patient showing signs of impending thyroid crisis, raise the room temperature for the patient with myxedema, explore the patient's reasons for noncompliance with dietary regimen)

III. Metabolic Mechanisms (25%)

This area includes the liver, gallbladder, and pancreas. This area focuses on the nursing care of patients with health problems such as cirrhosis, cholecystitis, insulin-dependent diabetes mellitus (type I), noninsulin-dependent diabetes mellitus (type II), pancreatitis, and cholelithiasis.

A. Theoretical framework — basis for care

1. Types of metabolic disorders

a. Responses to obstruction (for example: cholelithiasis, pancreatitis, cholecystitis)

b. Responses to toxic substances (for example: chronic pancreatitis, cirrhosis, hepatic coma)

c. Responses to inadequate production or utilization of secretions (for example: insulin-dependent diabetes mellitus [type I], noninsulin-dependent diabetes mellitus [type II])

2. Clinical manifestations of metabolic disorders

a. Altered fluid and electrolyte balance (for example: polyuria, polydipsia, muscle weakness, bradycardia, shallow respirations, diarrhea, hypotension, edema, cardiac dysrhythmia)

b. Altered nutrition (for example: anorexia, nausea, vomiting, polyphagia, dyspepsia)

c. Altered elimination (for example: clay-colored stool, frothy urine)

d. Altered appearance (for example: edema, ascites, jaundice, spider nevi)

e. Altered neurological function (for example: lethargy, memory loss, behavioral changes, decreased sensory perception, changes in fine motor control)

f. Altered comfort (for example: pain, fatigue)

g. Altered activity (for example: changes in sleep patterns, fatigue)

h. Altered respiratory function (for example: Kussmaul's respiration, dyspnea)

i. Altered circulatory functioning (for example: hypotension, tachycardia)

j. Altered integument (for example: pruritus, poor wound healing)

3. Factors influencing the patient's response to metabolic disorders

a. Age and physiological factors (for example: allergies)

b. Psychological factors (for example: stress, cognitive ability, body image, coping mechanisms)

c. Nutritional status (for example: obesity, malnutrition)

d. Presence of other illness (for example: infection, chronic illnesses)

e. Socioeconomic and cultural factors (for example: health practices, lifestyle, occupation, education, environmental factors)

f. Availability of support systems (for example: family, friends, community resources)

4. Theoretical basis for interventions related to metabolic disorders

a. Medications (for example: insulin, oral hypoglycemic agents, diuretics, vitamins, analgesics, antispasmodic agents, lactulose, propranolol)

b. Preoperative and postoperative care (for example: cholecystectomy [abdominal and laparoscopic], choledochostomy)

c. Treatment modalities (for example: diabetic exchange diet, low-protein diet, double-balloon tamponade)

d. Health instruction (for example: rationale for preventive measures, lifestyle changes, risk factors)

B. Nursing care related to theoretical framework

1. ***Assessment*** — gather and synthesize data about the patient's health status in relation to the patient's functional health patterns

a. Gather assessment data

1) Obtain the patient's health history (for example: subjective symptoms, diet, medications, drug and alcohol use, past illnesses, family history, allergies, impact of illness on family/occupational roles)

2) Assess factors influencing the patient's response to metabolic disorders (see IIIA3)

3) Obtain objective data related to the patient's metabolic disorder (for example: alterations in vital signs, integument, weight, abdominal girth, psychomotor function)

4) Review laboratory and diagnostic data (for example: blood chemistry, serum enzyme levels, liver function studies, biopsy, scans, glycosylated hemoglobin)

b. Synthesize assessment data (see IIIB1a[1-4])

2. ***Analysis*** — identify the nursing diagnosis (patient problem) and determine the expected outcomes (goals) of patient care

a. Identify actual or potential nursing diagnoses (for example: risk for injury: bleeding related to vitamin K deficiency; ineffective breathing pattern related to incisional pain; altered nutrition: less than body requirements related to vomiting and anorexia; noncompliance related to denial of illness; knowledge deficit: administration of insulin related to lack of information; risk for injury related to confusion)

b. Set priorities (for example: based on Maslow's hierarchy of needs, based on the patient's developmental level)

c. Establish expected outcomes (patient-centered goals) for care (for example: patient will not experience bleeding, patient will list foods high in sodium, patient will increase caloric intake to 2,000 calories, patient will demonstrate correct administration of insulin, patient will remain free of injury)

3. ***Planning*** — formulate specific strategies to achieve the expected outcomes

a. Consider factors influencing the patient's response to metabolic disorders (see IIIA3)

b. Plan nursing measures on the basis of established priorities to help the patient achieve the expected outcomes (for example: plan to instruct the patient about safe oral hygiene practices, plan to provide the patient with a list of high-sodium foods, plan to provide oral care frequently, plan to show the patient a videotape regarding the administration of insulin, plan protective measures)

4. ***Implementation*** — carry out nursing plans designed to move the patient toward the expected outcomes
   a. Use nursing measures to provide a safe environment (for example: provide the patient with a soft toothbrush, pad the siderails for a patient who is confused, eliminate obstacles from the ambulatory path of a patient with neuropathy)
   b. Use nursing measures to promote comfort (for example: place the patient with ascites in position of comfort, administer medications for pain relief, control the environmental temperature for the patient with pruritus, provide mouth care for a patient with a double-balloon tamponade)
   c. Use nursing measures specific to prescribed medications (for example: monitor serum glucose for a patient who is receiving insulin, monitor electrolytes for a patient who is receiving diuretics, monitor serum prothrombin times for a patient who is receiving vitamin K, monitor pulse for a patient who is receiving propranolol)
   d. Use nursing measures to prevent/minimize complications due to metabolic disorders (for example: provide skin and nail care for the patient with diabetes mellitus, rotate insulin sites for the patient with diabetes mellitus, use small-gauge needles for injections for the patient with bleeding tendencies, apply pressure to injection sites for 5–10 minutes to minimize bleeding tendencies, test the stool of a patient with a bleeding disorder for occult blood, monitor bleeding following biopsies)
   e. Use nursing measures to enhance utilization of coping mechanisms and support systems (for example: provide information about available age-appropriate support services, such as camps for children with diabetes mellitus; encourage the patient and family to participate in decision making; encourage verbalization of feelings related to the grief process and loss of function)
   f. Use nursing measures to provide information and instruction (for example: review predisposing factors with the patient with noninsulin-dependent diabetes mellitus [type II], instruct the patient with cirrhosis to read labels when shopping for food, encourage the patient with diabetes mellitus to schedule an annual eye examination, instruct the patient with diabetes mellitus about foot care)

5. ***Evaluation*** — appraise the effectiveness of the nursing interventions relative to the nursing diagnosis and the expected outcomes
   a. Assess and report the patient's response to nursing actions (for example: appetite has changed, nausea and vomiting is relieved, patient reports relief from pain, bleeding is minimized, skin is intact, weight is stable)
   b. Revise the patient's plan of care as necessary (for example: consider alternate methods of pain relief to enhance medication effectiveness, increase observation of a patient with an increased serum amylase level, reevaluate fluid and nutritional intake when a patient with cirrhosis continues to gain weight, review the diet and exercise program of a patient with diabetes mellitus whose glycosylated hemoglobin level remains elevated)

IV. Congenital Anomalies, Genetic Disorders, and Developmental Problems (10%)

This area includes congenital anomalies, which are those acquired during fetal development in utero; genetic disorders, which are hereditary in nature; and developmental problems, which interfere with normal growth and development. This area focuses on the nursing care of patients with health problems such as cardiac anomalies, cystic fibrosis, hemophilia, hydrocephalus, Down syndrome, phenylketonuria (PKU), meningomyelocele (spina bifida), muscular dystrophy, cerebral palsy, clubfoot, developmental dysplasia of the hip, Hirschsprung's disease, tracheoesophageal fistula, imperforate anus, congenital heart disease, biliary atresia, and mental retardation.

A. Theoretical framework — basis for care

1. Types of congenital anomalies, genetic disorders, and developmental problems
   a. Problems affecting oxygenation (for example: tetralogy of Fallot, patent ductus arteriosus, cystic fibrosis, hemophilia, sickle cell anemia)
   b. Problems affecting alimentation (for example: Hirschsprung's disease, tracheoesophageal fistula, imperforate anus, cleft palate)
   c. Problems affecting mobility (for example: meningomyelocele, muscular dystrophy, cerebral palsy, clubfoot, developmental dysplasia of the hip)
   d. Problems affecting mental function (for example: PKU, Down syndrome, hydrocephalus)

2. Clinical manifestations of congenital anomalies, genetic disorders, and developmental problems
   a. Altered respiratory functioning (for example: increased amount and viscosity of secretions, tachypnea, crackles, cough)
   b. Altered gastrointestinal functioning (for example: vomiting, inability to suck, abdominal distention, constipation, obstipation, fatty stools, indigestion)
   c. Altered mobility (for example: paralysis, weakness, spastic gait, choreiform movements, retarded physical development)
   d. Altered neurological status (for example: retarded mental development, seizures, increased intracranial pressure, impulsive behaviors)
   e. Altered urinary elimination (for example: incontinence, abnormal opening)
   f. Altered fluid and electrolyte balance (for example: hypovolemia)
   g. Altered appearance (for example: clubbed fingers, frontal enlargement, bulging fontanelle)
   h. Altered comfort (for example: pain, fatigue)
   i. Altered circulatory function (for example: dysrhythmias, tachycardia)
   j. Altered integument (for example: skin breakdown, abnormal opening)

3. Factors influencing the patient's response to congenital anomalies, genetic disorders, and developmental problems
   a. Age and physiological factors (for example: allergies)
   b. Psychological factors (for example: awareness of problem, behavioral manifestations, impulse control, parental and family responses)
   c. Nutritional status (for example: malnutrition, obesity)
   d. Presence of other illness (for example: infection)
   e. Site of congenital anomaly or genetic problem (for example: facial, genital, musculoskeletal, systemic)
   f. Socioeconomic and cultural factors (for example: access to health care, religious and cultural beliefs, lifestyle, occupation, education)
   g. Extent or severity of involvement (for example: operable vs. incurable or progressively deteriorating)

h. Availability of support systems (for example: family, friends, community resources)

4. Theoretical basis for interventions related to congenital anomalies, genetic disorders, and developmental problems
   a. Medications (for example: enzymes, diuretics, cardiac glycosides)
   b. Preoperative and postoperative care (for example: repair of clubfoot, imperforate anus, tetralogy of Fallot)
   c. Genetic counseling (for example: Tay-Sachs disease, cystic fibrosis)
   d. Treatment modalities (for example: dietary modifications, pulmonary therapy, mobility devices)
   e. Health instruction (for example: rationale for preventive measures, risk factors)

B. Nursing care related to theoretical framework

1. *Assessment* — gather and synthesize data about the patient's health status in relation to the patient's functional health patterns
   a. Gather assessment data
      1) Obtain the patient's health history (for example: subjective symptoms, diet, medications, past illnesses, family history, developmental task achievement, sleeping patterns, immunizations, growth and developmental data)
      2) Assess factors influencing the patient's response to congenital anomalies and genetic problems (see IVA3)
      3) Obtain objective data related to the patient's health problem (for example: breath sounds, altered integument, gait, developmental task achievement, growth rate, sensory-motor ability, physical abnormalities, altered vital signs, general appearance, head size, energy level)
      4) Review laboratory and other diagnostic data (for example: chest X ray, skeletal X ray, sweat test, complete blood count [CBC], arterial blood gases [ABG], electrocardiogram [EKG], barium enema, ultrasound, magnetic resonance imaging [MRI])
   b. Synthesize assessment data (see IVB1a[1-4])

2. *Analysis* — identify the nursing diagnosis (patient problem) and determine the expected outcomes (goals) of patient care
   a. Identify actual or potential nursing diagnoses (for example: altered family process related to situational crisis; activity intolerance related to imbalance between oxygen supply and demand; risk for infection related to pulmonary congestion; impaired mobility related to neuromuscular problems; altered cerebral tissue perfusion related to increased intracranial pressure; altered nutrition: less than body requirements related to inadequate pancreatic enzymes)
   b. Set priorities (for example: based on Maslow's hierarchy of needs, based on the patient's developmental level)
   c. Establish expected outcomes (patient-centered goals) for care (for example: family will demonstrate understanding of child's abilities, child will be free of cyanosis during morning care, patient will move independently with the aid of assistive devices, head circumference will remain stable, child will be free of irritability and headaches and will have vital signs within normal limits, patient will be free of abdominal distention, stools will be brown and of medium consistency and size)

3. *Planning* — formulate specific strategies to achieve the expected outcomes
   a. Consider factors influencing the patient's response to congenital anomalies and genetic problems (for example: site of anomaly, severity of problem, patient's access to health care [see IVA3])

b. Plan nursing measures on the basis of established priorities to help the patient achieve the expected outcomes (for example: plan to change the child's position frequently, schedule rest periods, establish a schedule for chest physiotherapy, plan instruction regarding assistive devices)

4. ***Implementation*** — carry out nursing interventions designed to move the patient toward the expected outcomes
   a. Use nursing measures to assist the patient and family to cope with the disability (for example: use therapeutic communication, make referrals to support groups)
   b. Use nursing measures to promote, maintain, or restore physiological functioning (for example: establish a rest schedule for the patient with a cardiac anomaly, provide chest physiotherapy for a patient with cystic fibrosis, elevate the head of the bed for a patient with hydrocephalus, position the child with a meningomyelocele on the abdomen)
   c. Use nursing measures to stimulate and encourage psychosocial development (for example: use appropriate verbal communication, provide assistance and encouragement for the child to perform developmental tasks, encourage age-appropriate play activities)
   d. Use nursing measures to prevent/minimize complications (for example: monitor vital signs, use sterile technique during dressing changes, position the child to prevent contamination from urine and stool)
   e. Use nursing measures to provide comfort, rest, and sleep (for example: maintain bedtime routines; provide a quiet, calm environment; position for comfort; relieve abdominal distention)
   f. Use nursing measures specific to prescribed medications (for example: take the pulse prior to administering digitalis, check for response to pain-relieving medications, check for allergies prior to administering antibiotics, administer pancreatic enzymes with meals)
   g. Use nursing measures to provide information and instruction (for example: instruct the family about low-phenylalanine diet, provide skin care instruction for a patient who is wearing a brace, instruct the family in positioning techniques for the child with hydrocephalus, instruct the family in postural drainage techniques)

5. ***Evaluation*** — appraise the effectiveness of the nursing interventions relative to the nursing diagnosis and the expected outcomes
   a. Assess and report the patient's response to nursing actions relative to the expected outcomes (for example: changes in elimination patterns, head circumference, ability to ingest food; achievement of bowel and bladder function; achievement of developmental tasks)
   b. Revise the patient's plan of care as necessary (for example: consider addition of percussion to postural drainage program for a child with cystic fibrosis, obtain self-help devices for the patient with a progressive coordination disability)

Sample Questions

The questions that follow illustrate those typically found on this examination. These sample questions are included to familiarize you with the type of questions you will find on the examination. The answers can be found on the inside back cover of this guide.

1. Which finding is common in patients during the manic phase of bipolar disorder?
   1) delusional thought patterns
   2) psychomotor retardation
   3) excessive sleepiness
   4) passive communication style

2. Which affective state is typically observed in patients with schizophrenia?
   1) anger
   2) apathy
   3) euphoria
   4) sadness

3. Which is a characteristic of a patient with a passive-aggressive personality disorder?
   The patient
   1) suspects the motives of others.
   2) displays a high degree of insight.
   3) shows insensitivity to the feelings of others.
   4) displays manipulative behaviors.

4. Which side effects are associated with the use of lithium carbonate (Eskalith)?
   1) blurred vision, tremors, and diarrhea
   2) neutropenia, palpitations, and drowsiness
   3) psychological dependence, ataxia, and depression
   4) akathisia, tardive dyskinesia, and delusions

5. A female patient is admitted to the emergency department after having been abducted and raped. Which patient behavior illustrates use of the defense mechanism of dissociation?
   1) The patient states that she is fine and does not need to be hospitalized.
   2) The patient states that she does not have any recollection of the incident.
   3) The patient discusses the incident in a matter-of-fact manner.
   4) The patient states that she knows she needs follow-up care but does not want to talk about it.

6. Which nursing diagnosis should receive priority for a hospitalized patient who demonstrates suspicious behavior?
   1) anxiety related to lack of trust in new environment and caregivers
   2) impaired verbal communication related to argumentative speech patterns
   3) self-esteem disturbance related to inaccurate self-perception
   4) social isolation related to withdrawal from interactions with others

7. Which goal should the nurse include in the plan of care for a patient with a diagnostic category of high risk for self-directed violence?
   1) The patient's use of tranquilizers will decrease.
   2) The patient will seek out mutual relationships.
   3) The patient will demonstrate an increased ability to concentrate.
   4) The patient will seek out staff when suicidal ideation occurs.

8. Which goal should be included in the plan of care for a patient who is a victim of spouse abuse?

   The patient will

   1) articulate a safety plan for use in abusive situations.
   2) understand the psychodynamics of the abusive behavior.
   3) identify ways in which the abuse could have been avoided.
   4) verbalize the reasons for the abuse.

9. When a patient with schizophrenia begins to hallucinate, the nurse should take which action?

   1) Provide the patient with privacy.
   2) Administer the ordered antianxiety medication.
   3) Redirect the patient to activities focused on the here and now.
   4) Convince the patient that the hallucination is not real.

10. A patient with obsessive behavior spends so much time at ritual handwashing that he misses the scheduled breakfast time each morning. Which action should the nurse take?

    1) Insist that the patient stop the handwashing when it is time for breakfast.
    2) Restrict the patient's access to the sink until after breakfast.
    3) Awaken the patient early, so that the handwashing can be completed before breakfast.
    4) Ask the patient to postpone the handwashing until after breakfast.

11. Which action should the nurse take when a patient who is receiving an antipsychotic medication exhibits muscle rigidity and tremors?

    1) Administer the ordered antiparkinsonian medication.
    2) Withhold the medication and continue to observe the patient.
    3) Inform the patient that these are expected side effects of the medication.
    4) Request the physician to increase the dosage of medication.

12. Which alteration in the integument is a clinical manifestation of diabetes insipidus?

    1) cool, clammy skin
    2) edema
    3) poor skin turgor
    4) pruritus

13. A patient with Addison's disease who is on corticosteroid therapy may be at risk for the development of which health problem?

    1) fine hand tremors
    2) hyperkalemia
    3) infection
    4) weight loss

14. How should the nurse assess a patient for hemorrhage following a thyroidectomy?

    1) Loosen one edge of the dressing to examine the incisional line.
    2) Gently lift the patient to check the bed linens for bloody drainage.
    3) Roll the patient to the side to examine the sides and back of the neck.
    4) Examine the posterior pharynx for evidence of bleeding.

15. Which laboratory finding supports a diagnostic category of activity intolerance in a patient with chronic renal failure?

    1) decreased hemoglobin
    2) decreased serum magnesium
    3) increased serum bicarbonate
    4) increased serum phosphate

16. A patient is in the diuretic phase of acute renal failure. Which action by the nurse demonstrates awareness of the physiological changes that are occurring?

    1) Check for a positive Chvostek's sign.
    2) Observe the neck for distended veins.
    3) Attempt to elicit Trousseau's sign.
    4) Assess the apical pulse for irregularities.

17. Which discharge instruction should the nurse give to a patient who is receiving hormone therapy for hypothyroidism?
    1) Decrease the dosage when symptoms subside.
    2) Expect palpitations and diaphoresis to occur.
    3) Take the medication at the same time each day.
    4) Take the medication with meals.

18. Which serum elevation may contribute to the development of hepatic encephalopathy?
    1) hyperglycemia
    2) hyperkalemia
    3) hypernatremia
    4) hyperproteinemia

19. Which nursing assessment should receive priority for a patient with cirrhosis who has esophageal varices?
    1) bilirubin levels
    2) skin color
    3) urinary output
    4) vital signs

20. A patient with hepatic dysfunction complains of itching. The nurse should associate the itching with which other assessment finding?
    1) anorexia
    2) ascites
    3) jaundice
    4) malnutrition

21. Which nursing diagnosis would be appropriate for a patient with chronic pancreatitis?
    1) colonic constipation related to immobility
    2) impaired tissue integrity related to mechanical destruction
    3) ineffective breathing pattern related to pain
    4) risk for injury related to sensory deficits

22. Which measure should the nurse include in the plan of care for a patient who has a liver dysfunction?
    1) Use small-gauge needles for injections, to minimize bleeding tendencies.
    2) Bathe the patient frequently, to remove oil and salts from the skin.
    3) Monitor the vital signs closely, to detect hypotension.
    4) Use physical restraints as necessary, to control excessive motor activity.

23. Which nursing intervention should receive priority for a patient with acute pancreatitis?
    1) monitoring the patient's intake and output
    2) relieving the patient's pain
    3) changing the patient's position frequently
    4) monitoring the patient's lab values

24. The nurse should instruct a patient with cirrhosis of the liver who has ascites to adhere to which type of diet?
    1) high-fat
    2) high-fiber
    3) low-carbohydrate
    4) low-sodium

25. Which statement by a patient with insulin-dependent diabetes mellitus (type I) indicates that the patient understands the symptoms of hypoglycemia that should be reported?
    1) "I will watch for increased urination and nausea."
    2) "I will watch for sweating and shakiness."
    3) "I will watch for unusual thirst and rapid breathing."
    4) "I will watch for dry skin and fruity breath odor."

26. Why do children with tetralogy of Fallot frequently assume a squatting position?
    1) to decrease postural hypotension
    2) to increase peripheral circulation
    3) to maximize peripheral resistance
    4) to relieve chronic hypoxia

27. Which information in an infant's health history is most consistent with a diagnosis of Hirschsprung's disease?
    1) greasy stools
    2) chronic constipation
    3) projectile vomiting
    4) frequent respiratory infections

28. The nurse's assessment of a neonate with a meningomyelocele should focus on which area?
    1) the extent of the neurological deficit
    2) the degree of respiratory paralysis
    3) the amount of pain associated with movement
    4) the strength of the pharyngeal, laryngeal, and oral muscles

29. Which lunch choice by the parents of a two-year-old child indicates that they are maintaining their child on a low-phenylalanine diet?
    1) chicken salad
    2) fruit salad
    3) egg salad sandwich
    4) peanut butter and jelly sandwich

Learning Resources for this Exam

The study materials listed are recommended by Excelsior College as the most appropriate resources to help you study for the examination. Those listed as Recommended Resources are essential to your understanding of the content. The Additional Resources may provide clarification for some of the topics on the content outline, or provide enrichment in areas of interest.

This exam is one of seven (7) written examinations required of students in the Excelsior College associate degree programs in nursing:

Nursing Concepts 1

Nursing Concepts 2

Nursing Concepts 3

Differences in Nursing Care: Area A (modified)

Differences in Nursing Care: Area B

Differences in Nursing Care: Area C

Occupational Strategies in Nursing

Important: The examinations in Commonalities in Nursing Care: Areas A and B have been withdrawn and the examination in Differences in Nursing Care: Area A will exist in a modified form only through September 30, 2001, after which it will be replaced with Nursing Concepts 4. Students in the Excelsior College AAS(n) and AS(n) degree programs who have not completed Commonalities A and B and Differences A by September 30, 2000 will be required to complete Nursing Concepts 1, 2, and 3 and the modified Differences A—and enroll by February 1, 2001—to use any old-series examinations toward completion of their degree. The current examination in Differences B will be replaced in October 2001 by Nursing Concepts 5, and the examinations in Differences C and Occupational Strategies will be replaced in October 2002 by Nursing Concepts 6 and 7.

If you are planning to take several of the associate degree nursing examinations, you will need to begin building a library of nursing textbooks. For this examination, you should obtain one textbook from each of the following nursing practice areas: medical-surgical, pediatrics, nursing diagnosis, psychiatric nursing, and pharmacology. In addition, textbooks in anatomy and physiology, microbiology, and nutrition will supplement your study. You may want to arrange to have access to textbooks in these areas.

For information on ordering from the Excelsior College Bookstore, see p. 2. You may also find resource materials in college libraries. Public libraries may have some of the textbooks or may be able to obtain them through an interlibrary loan program.

You should allow sufficient time to obtain resources and to study before taking the exam.

Recommended Resources

Textbooks

The examination development committee recommends that you obtain one textbook in each of the five areas listed on the following pages for use in preparing for the examination. Each of the textbooks provides in-depth exploration of the material in the content areas to be tested. In addition, most of them have a companion study guide. If you would like assistance in organizing your study and reviewing the material in the textbooks, the committee recommends that you consider purchasing the study guides as well.

The recommended textbooks and their companion study guides are listed on the following pages. Accompanying each entry is a brief description of the materials. This description may assist you in deciding which of the materials to obtain. You do <u>not</u> need to purchase two textbooks in an area. You may prefer a certain author or the way in which the material is presented. When two textbooks are listed, <u>either</u> of them will meet your study needs. If you encounter topics in the content outline that are not covered in the textbook you are using, you should supplement your study with another textbook.

Medical-Surgical Nursing

Smeltzer, S., & Bare, B. (1996). *Brunner and Suddarth's Textbook of medical-surgical nursing* (8th ed.). Philadelphia: J.B. Lippincott.

This textbook makes extensive use of diagrams, tables, photographs, charts, and nursing care plans to present information. Each chapter begins with learning objectives and ends with critical-thinking activities and a bibliography. Many color photographs are included. The textbook contains a free self-study disk with sample test questions and rationales for the correct answer.

Study Guide:

Boyer, M.J. (1996). *Study guide to accompany Brunner and Suddarth's Textbook of medical-surgical nursing* (8th ed.). Philadelphia: J.B. Lippincott.

OR

Phipps, W. et al. (1999). *Medical-surgical nursing: Concepts and clinical practice* (6th ed.). St. Louis: Mosby.

Each chapter begins with learning objectives and key terms and concludes with a chapter summary, questions for the learner to consider, and critical-thinking activities. Examples of nursing care plans and critical pathways are included. This textbook relies more on written material to explore the content. It contains fewer pictures, diagrams, tables, and charts than the Smeltzer text provides.

Study Guide:

Phipps, W. et al. (1999). *Student learning guide to accompany medical-surgical nursing* (6th ed.). St. Louis: Mosby.

Nursing Diagnosis

Carpenito, L.J. (1997). *Nursing diagnosis: Application to clinical practice* (7th ed.). Philadelphia: J.B. Lippincott.

OR

Wilkinson, J.M. (1996). *Nursing process: A critical thinking approach* (2nd ed.). St. Louis: Mosby.

Pediatrics

Wong, D. (1997). *Whaley and Wong's Essentials of pediatric nursing* (5th ed.). St. Louis: Mosby.

This textbook presents learning objectives for each chapter and contains many color photographs. Guidelines and emergency treatments are presented in boxes within each chapter. Hundreds of tables, boxes, and diagrams are used to highlight key concepts. Key points are summarized at the end of each chapter.

Study Guide:

Murphy, A. (1997). *Study guide to accompany Whaley and Wong's Essentials of pediatric nursing* (5th ed.). St. Louis: Mosby.

Pharmacology

McKenry, L., & Salerno, E. (1995). *Mosby's Pharmacology in nursing* (19th ed.). St. Louis: Mosby.

Each chapter in this textbook begins with a review of anatomy and physiology and a discussion of the drug group. Summary tables and boxes supplement and reinforce the material and make comparisons among similar drugs. The textbook also includes information regarding implications for the care of children, older adults, and pregnant patients. The textbook includes a set of removable drug category cards.

Study Guide:

McKenry, L., & Salerno, E. (1995). *Student learning guide for Mosby's Pharmacology in nursing* (19th ed.). St. Louis: Mosby.

OR

Shlafer, M. (1993). *The nurse, pharmacology, and drug therapy: A prototype approach* (2nd ed.). Menlo Park, CA: Addison-Wesley.

Each chapter begins with an overview of the anatomy and physiology for each system. A prototype drug is used in each drug category and a holistic approach to patient care is emphasized. Implications for the care of children, older adults, and pregnant patients are discussed in each chapter. A summary on implications for the nursing process is discussed for each drug category at the end of each chapter. The book contains a set of removable prototype drug cards.

There is no study guide to accompany this text.

Psychatric Nursing

Varcarolis, E. (1998). *Foundations of psychiatric mental health nursing* (3rd ed.). Philadelphia: W.B. Saunders.

This textbook uses anxiety and the mental health continuum as the organizing framework. Each chapter begins with an outline, a list of key terms and concepts, and objectives. Chapters discussing psychiatric disorders are written in a nursing process framework with sample care plans and case studies included. Figures and tables highlight key concepts. Each chapter ends with a variety of self-study exercises.

There is no study guide to accompany this text.

OR

Townsend, M. (1996). *Psychiatric mental health nursing: Concepts of care* (2nd ed.). Philadelphia: F.A. Davis.

This textbook uses stress-adaptation as its conceptual framework. It has incorporated changes reflective of the DSM-IV. Each chapter begins with a chapter outline, key terms, and objectives. Case studies, critical pathways, and care plans are included. Figures and tables highlight key concepts. Each chapter ends with review questions.

There is no study guide to accompany this text.

Additional Resources

The following resources are suggested to supplement your understanding of the material presented in the recommended resources. These resources include textbooks, journal articles, and audiovisual materials. They were selected because they are current and relevant to the content to be tested by this examination. You are encouraged to read widely; you may find other textbooks, articles, or audiovisual resources to be of interest. These additional resources are an important supplementary learning activity because they address issues that are of interest to practicing nurses and provide "real world" examples of how the theory in textbooks can be applied to actual clinical situations.

You should be able to find many of these resources at a nearby school of nursing library, college library, or hospital library. You might also find them at your state nurses association library. In addition, your local public librarian may be able to assist you with an interlibrary loan request. It is not necessary to purchase these resources.

Textbooks

The textbooks below may provide further clarification or enrichment in the areas of aging and nutrition.

Eliopoulos, C. (1997). *Gerontological nursing* (4th ed.). Philadelphia: J.B. Lippincott.

This textbook presents in-depth content on older adults, including their role in the family and the common changes that occur with aging. The changing needs of older adults are addressed in depth, as well as specific health problems and appropriate modifications in care. Assessment data, nursing diagnoses, and nursing care plans are highlighted in each chapter. Critical-thinking exercises are included at the end of each chapter.

Williams, S.R. (1994). *Essentials of nutrition and diet therapy* (6th ed.). St. Louis: Mosby.

This textbook uses chapter outlines to introduce the learner to the topics. Each chapter opens with an illustration and brief opening paragraph. Chapter summaries and review questions are included. A special feature in each chapter is a brief article on a nutrition-related issue. The textbook includes color photographs, tables, and charts.

Journal Articles

Because journal articles tend to be written in a simple, straightforward manner, you may find them useful in explaining or expanding upon difficult concepts. Many articles include case studies or post-tests to help you assess your learning. You may also find them helpful in providing an "inside view" of areas of nursing practice with which you are not familiar. You may want to review nursing journals from this year to locate more current articles.

As a professional nurse, you have a responsibility to continue your education. One way you can keep current is by reading journal articles. Subscribing to one or two journals is a helpful way to gain exposure to current articles in the field.

I. Behavioral Responses–Observable Responses of the Individual to Life Stressors

Amora, A., & Cerrato, P. (1996). Eating disorders – still a threat. *RN, 59*(6), 30–35.

Antai-Otong, D. (1995). Helping the alcoholic patient recover. *American Journal of Nursing, 95*(8), 22–30.

Badger, J. (1995). Reaching out to the suicidal patient. *American Journal of Nursing, 95*(3), 24–32.

Barstow, D. (1995). Self-injury and self-mutilation. *Journal of Psychosocial Nursing and Mental Health Services, 33*(2), 19–22.

Burgess, A., Burgess, A., & Douglas, J. (1994). Examining violence in the workplace: A look at work related fatalities. *Journal of Psychosocial Nursing and Mental Health Services, 32*(7), 11–18, 53.

Chez, N. (1994). Helping the victim of domestic violence. *American Journal of Nursing, 94*(7), 33–37.

D'Arrigo, T. (1994). Depression and recovery in home care patients. *Caring, 13*(6), 42–46.

Fitzsimmons, L. (1995). Electroconvulsive therapy: What nurses need to know. *Journal of Psychosocial Nursing and Mental Health Services, 33*(12), 4–17.

Hall, G. (1996). Managing acute confusion in the elderly. *Nursing '96, 26*(7), 33–37.

Henderson, A., & Ericksen J. (1994). Enhancing nurses' effectiveness with abused women: Awareness, reframing, support, education. *Journal of Psychosocial Nursing and Mental Health Services, 32*(6), 11–15.

Lynch, S. (1997). Elder abuse: What to look for, how to intervene. *American Journal of Nursing, 97*(1), 27–32.

Navaria, T. (1995). Enabling behavior: The tender trap. *American Journal of Nursing, 95*(1), 50–52.

Spear, H. (1996). Anxiety – when to worry, what to do. *RN, 59*(7), 40–46.

Stolley, J.M. (1994). When your patient has Alzheimer's disease. *American Journal of Nursing, 94*(8), 34–41.

Valente, S. (1994). Recognizing depression in elderly patients. *American Journal of Nursing, 94*(12), 18–25.

II. Regulatory Mechanisms

Angelucci, P. (1995). Caring for patients with hypothyroidism. *Nursing '95, 25*(5), 60–61.

Howser, R. (1995). What you need to know about corticosteroid therapy. *American Journal of Nursing, 95*(8), 44–49.

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III. Metabolic Mechanism

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IV. Congenital Anomalies, Genetic Disorders, and Developmental Problems

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Audiovisual Resources

Audiovisual resources include materials such as audiocassettes, videotapes, computer-assisted instruction, and interactive videodiscs. Audiovisual resources are also supplemental to your textbook readings. They may be available for viewing at a nearby school of nursing library or a hospital library. Since such resources are costly, purchase is not recommended.

Videocassettes

1. Fanlight Productions, 47 Halifax Street, Boston, MA 02130

   Four lives

2. Insight Media, 2162 Broadway, New York, NY 10024, Phone: 212-721-6316

   Communication with clients with mental disorders or emotional problems

   Controlling violence in health care

   Domestic violence: Behind closed doors

   Treating borderline personality disorders

3. Concept Media, P.O. Box 19542, Irvine, CA 92623-9542, Phone: 800-233-7078

   Techniques of therapeutic communication

   Blocks to therapeutic communication

   Interactions for study

Interactive Videodiscs

FITNE, 5 Depot Street, Athens, OH 45701, Phone: 614-592-2511

Therapeutic communication

Computer-Assisted Instruction

1. Lippincott Williams & Wilkins, P.O. Box 1600, Hagerstown, MD 21741, Phone: 800-638-3030

   Clinical simulations in nursing I, Psychiatric nursing series

   Clinical simulations in nursing II, Psychiatric nursing series

   Clinical simulations in mental health nursing III

   Critical care nursing simulations: Endocrine system series

   Clinical simulations in nursing, Pediatric nursing simulations I

   Clinical simulations in nursing, Pediatric nursing simulations II

   Nursing care of patients with anxiety disorders

2. Lippincott-Raven Publishers, Audiovisual Department, 227 East Washington Square, Philadelphia, PA 19106, Phone: 800-523-2945

   Nurs-comps: Clients with bipolar disorder, manic episode

   Nurs-comps: Nursing interventions for an adolescent with anorexia nervosa

   Nurs-comps: Nursing interventions for the client with anxiety

   Nursing: Mr. Drew, an adult who abuses alcohol

   Nursing: Ms. Alt, a young adult with depression

3. Computerized Educational Systems, 307 Park Lake Circle, P.O. Box 536905, Orlando, FL 32853-6905, Phone: 800-275-1474

   Care of the client with borderline personality disorder

   Therapeutic communication with the chemically dependent client

   Therapeutic counseling session

Content/Reference List

Listed below are the chapters in the recommended resources that cover the material in each content area. The list may help you locate the topics in the content outline. The list is not intended to be comprehensive. To cover all of the material in this study guide, you may need to refer to other chapters in the reference textbooks. Chapter numbers and titles may differ in subsequent editions.

I. Behavioral Responses–Observable Responses of the Individual to Life Stressors

McKenry & Salerno (19th ed., 1995)
- Ch. 14 – Antianxiety, Sedative, and Hypnotic Drugs
- Ch. 17 – Psychotherapeutic Drugs
- Ch. 18 – Drugs for Specific CNS-Peripheral Dysfunctions

Shlafer (2nd ed., 1993)
- Ch. 22 – Sedatives, Hypnotics, Anxiolytics
- Ch. 23 – Antipsychotic Drugs
- Ch. 24 – Drugs for Treatment of Depression and Mania

Townsend (2nd ed., 1996)
- Ch. 1 – An Introduction to the Concept of Stress
- Ch. 2 – Mental Health and Mental Illness
- Ch. 3 – Theories of Personality Development
- Ch. 5 – Relationship Development
- Ch. 6 – Therapeutic Communication
- Ch. 7 – The Nursing Process in Psychiatric/Mental Health Nursing
- Ch. 8 – Therapeutic Groups
- Ch. 9 – Intervention with Families
- Ch. 10 – Milieu Therapy – The Therapeutic Community
- Ch. 11 – Crisis Intervention
- Ch. 12 – Relaxation Therapy
- Ch. 15 – Anger/Aggression Management
- Ch. 16 – The Suicidal Client
- Ch. 17 – Behavior Therapy
- Ch. 18 – Psychopharmacology
- Ch. 19 – Electroconvulsive Therapy
- Ch. 20 – Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
- Ch. 21 – Delirium, Dementia, and Amnestic Disorders
- Ch. 22 – Substance-Related Disorders
- Ch. 23 – Schizophrenia and Other Psychotic Disorders
- Ch. 24 – Mood Disorders
- Ch. 25 – Anxiety Disorders
- Ch. 26 – Somatoform and Sleep Disorders
- Ch. 27 – Dissociative Disorders
- Ch. 29 – Eating Disorders
- Ch. 31 – Psychological Factors Affecting Medical Conditions
- Ch. 32 – Personality Disorders
- Ch. 33 – The Aging Individual
- Ch. 35 – Problems Related to Abuse or Neglect
- Ch. 37 – Cultural Concepts Relevant to Psychiatric/Mental Health Nursing

Varcarolis (3rd ed., 1998)
- Ch. 2 – Mental Health: Theories and Therapies
- Ch. 5 – Framework for Culturally Relevant Psychiatric Nursing
- Ch. 6 – The Nurse-Client Relationship and the Nursing Process
- Ch. 7 – Communication and the Clinical Interview
- Ch. 8 – Psychiatric Nursing in the Acute Psychiatric Hospital
- Ch. 10 – Communication within Groups
- Ch. 13 – Reducing Stress and Anxiety
- Ch. 14 – Crisis and Crisis Intervention
- Ch. 15 – Families in Crisis: Family Violence
- Ch. 16 – Rape
- Ch. 17 – Anxiety Disorders
- Ch. 18 – Somatoform and Dissociative Disorders
- Ch. 19 – Personality Disorders
- Ch. 20 – Alterations in Mood: Grief and Depression
- Ch. 21 – Alterations in Mood: Elation in Bipolar Disorders
- Ch. 22 – Schizophrenic Disorders
- Ch. 23 – Cognitive Disorders
- Ch. 24 – People Who Contemplate Suicide
- Ch. 25 – People Who Depend Upon Substances of Abuse
- Ch. 26 – People with Eating Disorders
- Ch. 29 – Children and Adolescents

II. Regulatory Mechanisms

McKenry & Salerno (19th ed., 1995)
- Ch. 32 – Overview of the Urinary System
- Ch. 33 – Diuretics
- Ch. 35 – Drug Therapy for Renal System Dysfunction
- Ch. 46 – Overview of the Endocrine System
- Ch. 47 – Drugs Affecting the Pituitary
- Ch. 48 – Drugs Affecting the Parathyroid and Thyroid
- Ch. 49 – Drugs Affecting the Adrenal Cortex

Phipps (6th ed., 1999)
- Ch. 33 – Assessment of the Endocrine System
- Ch. 34 – Management of Persons with Problems of the Pituitary, Thyroid, Parathyroid, and Adrenal Glands
- Ch. 43 – Assessment of the Renal System
- Ch. 44 – Management of Persons with Problems of the Kidney and Urinary Tract
- Ch. 45 – Management of Persons with Renal Failure

Shlafer (2nd ed., 1993)
- Ch. 43 – Structure and Function of the Endocrine System
- Ch. 44 – Pituitary-Hypothalamic Relationships
- Ch. 45 – Adrenocorticosteroids
- Ch. 47 – Thyroid and Parathyroid Hormones and Antithyroid Drugs

Smeltzer (8th ed., 1996)
- Ch. 40 – Assessment and Management of Patients with Endocrine Disorders
- Ch. 41 – Assessment of Renal Function
- Ch. 42 – Management of Patients with Urinary and Renal Dysfunction
- Ch. 43 – Management of Patients with Urinary and Renal Disorders

Wong (5th ed., 1996)
- Ch. 27 – The Child with Genitourinary Dysfunction
- Ch. 29 – The Child with Endocrine Dysfunction

III. Metabolic Mechanism

McKenry & Salerno (19th ed., 1995)
- Ch. 50 – Drugs Affecting the Pancreas

Phipps (6th ed., 1999)
- Ch. 35 – Management of Persons with Diabetes Mellitus and Hypoglycemia
- Ch. 36 – Assessment of the Hepatic System
- Ch. 37 – Management of Persons with Problems of the Hepatic System
- Ch. 38 – Assessment of the Gastrointestinal, Biliary, and Exocrine Pancreatic Systems
- Ch. 42 – Management of Persons with Problems of the Gallbladder and Exocrine Pancreas

Shlafer (2nd ed., 1993)
- Ch. 46 – Drugs for Managing Diabetes Mellitus and Hypoglycemia

Smeltzer (8th ed., 1996)
- Ch. 38 – Assessment and Management of Patients with Hepatic and Biliary Disorders
- Ch. 39 – Assessment and Management of Patients with Diabetes Mellitus

Wong (5th ed., 1996)
- Ch. 24 – The Child with Gastrointestinal Dysfunction

IV. Congenital Anomalies, Genetic Disorders, and Developmental Problems

McKenry & Salerno (19th ed., 1995)
- Ch. 40 – Drugs Affecting the Upper Gastrointestinal Tract (Section on Digestants)

Wong (5th ed., 1997)
- Ch. 9 – Health Problems of Newborns
- Ch. 23 – The Child with Respiratory Dysfunction
- Ch. 24 – The Child with Gastrointestinal Dysfunction
- Ch. 25 – The Child with Cardiovascular Dysfunction
- Ch. 28 – The Child with Cerebral Dysfunction
- Ch. 31 – The Child with Musculoskeletal or Articular Dysfunction
- Ch. 32 – The Child with Neuromuscular or Muscular Dysfunction

Excelsior College Examination Development Committee in Differences in Nursing Care: Area B

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Key To Sample Questions

Question	Key	Content Area[1]	Question	Key	Content Area[1]
1	1	IA1a(4)	16	4	IIB4d
2	2	IA1d	17	3	IIB4f
3	4	IA1e(2)	18	4	IIIA2a
4	1	IA4l(1d)	19	4	IIIB1a(3)
5	2	IA2c	20	3	IIIB1b
6	1	IB2b	21	3	IIIB2a
7	4	IB2b	22	1	IIIB3b
8	1	IB2c	23	2	IIIB4b
9	3	IB4b	24	4	IIIB4f
10	3	IB4e	25	2	IIIB5a
11	1	IB4g	26	4	IVA2a
12	3	IIA2i	27	2	IVB1a(1)
13	3	IIA4a	28	1	IVB1a(3)
14	3	IIB1a(3)	29	2	IVB5a
15	1	IIB1a(4)			

[1]Content Area refers to the location of the question topic in the content outline.

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Examination	Credit Hrs.
Arts and Sciences	
Abnormal Psychology†	3*
American Dream†	6*
Anatomy & Physiology†	6
English Composition†	6
Ethics: Theory & Practice†	3*
Foundations of Gerontology	3*
History of Nazi Germany†	3*
Life Span Developmental Psychology†	3
Microbiology†	3
Organizational Behavior	3*
Pathophysiology	3*
Psychology of Adulthood & Aging	3*
Religions of the World†	3*
Research Methods in Psychology†	3*
Statistics†	3
World Population†	3*
Business	
Business Policy & Strategy	3△
Ethics: Theory & Practice	3*
Human Resource Management	3*
Labor Relations	3*
Organizational Behavior	3*
Production/Operations Management	3△
Education	
Reading Instruction in the Elementary School	6*

Examination	Credit Hrs.
Nursing: Associate Level	
Differences in Nursing Care: Area A (modified)①	4
Differences in Nursing Care: Area B①	5
Differences in Nursing Care: Area C②	5
Fundamentals of Nursing**	8
Maternal & Child Nursing (associate)**	6
Maternity Nursing**	3
Nursing Concepts 1	4
Nursing Concepts 2	4
Nursing Concepts 3	4
Occupational Strategies in Nursing②	3
Nursing: Baccalaureate Level	
Adult Nursing**	8*
Health Restoration: Area I	4*
Health Restoration: Area II	4*
Health Support A: Health Promotion & Health Protection	4*
Health Support B: Community Health Nursing	4*
Maternal & Child Nursing (baccalaureate)**	8*
Professional Strategies in Nursing	4*
Psychiatric/Mental Health Nursing**	8*
Research in Nursing†	3*

* Indicates upper-level college credit. **These examinations do not apply toward the Excelsior College Nursing Degrees. †Guided Learning Packages are available for these exams. △Indicates lower-level college credit for Business Program, upper-level for Liberal Arts Program. ①Administered through Sept. 30, 2001. ②Administered through Sept. 30, 2002.

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